ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

ANNUAL REPORT 1988

90-00546/

MEMBERS OF THE COMMITTEE 1988

Chairman:	Alan W. Hyland, M.L.A. (Cypress-Redcliff)	Edmonton
Vice Chairman and Complaints Co-ordinator	Colleen Wood	Edmonton (Resigned Oct. 1988)
	Mollie Warring	Edmonton (Appointed Oct. 1988)
Members:	Bert Berube	Leduc
	Doug Cherry, M.L.A. (Lloydminster)	Lloydminster
	Marsha Graham	Calgary
	Carol Losie	Edmonton
	Bernice McManus	Calgary
	Carolyn Mick	Innisfail
	Abe Remtulla	Calgary
	Sheila Stilling	Grande Prairie
	Sheila Torsher	Bow Island

The office of the Committee is located on the second floor of the Pacific Plaza, 10909 Jasper Avenue, Edmonton, T5J 3M9. Telephone 427 - 4924.

Executive Assistant::	Amelia Griffin	Edmonton
Secretary:	Margaret Dalton	Edmonton

Alberta
HEALTH FACILITIES REVIEW
COMMITTEE

2nd Floor, Pacific Plaza, 10909 Jasper Avenue, Edmonton, Alberta, Canada T5J 3M9 403/427-4924

13 February 1989

The Honourable Nancy Betkowski,
Minister of Health,
Room 130, Legislature Building,
EDMONTON, Alberta.

Dear Mrs. Betkowski:

I have the honour to present the Annual Report of the Alberta Health Facilities Review Committee, summarizing the activities of the Committee for the year ending 31 December 1988.

Respectfully submitted,

Alan W. Hyland

Alan W. Hyland, M.L.A.
Chairman

1988
ANNUAL REPORT

of

THE ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

Submitted to

THE HONOURABLE NANCY J. BETKOWSKI
Minister of Health

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MISSION STATEMENT

The mission of the Alberta Health Facilities Review Committee is to ensure that quality care, treatment and standards of accommodation are maintained in health care facilities and lodges across Alberta.

The Committee will provide the people of Alberta with a group of citizens to whom they may address their concerns relating to the care, treatment and standards of accommodation at a health care facility or lodge in the province.

The Health Facilities Review Committee acknowledges the importance of preserving the dignity and confidentiality of those individuals within the facilities the Committee visits.

The resources of the Committee are dedicated to ensuring that these values prevail in the delivery of care across the province of Alberta.

HISTORY OF ALBERTA HEALTH FACILITIES REVIEW COMMITTEE

The Alberta Health Facilities Review Committee is made up of twelve citizens from various centres in the Province. Members are appointed by Ministerial Order for terms ranging from one to three years, and are of varying ages and backgrounds. All members serve on the Committee on a part time basis, and are not employees of the Government.

The Committee has a mandate to visit health care facilities throughout the Province for the purpose of reviewing and inspecting them, and observing the manner in which they are operated. Institutions included are General Hospitals, Auxiliary Hospitals, Nursing Homes, Mental Health Facilities and Senior Citizens Lodges. Included in the mandate is the responsibility for receiving and investigating complaints about health care facilities.

All health care facilities are visited by Committee members on a regular basis. Visits to institutions are unannounced. They are planned monthly and are authorized by resolution of the Committee.

The visiting team reports on such areas as care, atmosphere, comfort, food, activities and programs, community involvement, patient morale, staff morale and general attitudes, and physical facilities. Members prefer to conduct the visits unaccompanied by staff members of the facility. Particular attention is given to discussions with patients, residents, and staff on a one-to-one basis. The committee sse its role as that of considering the institution from a patient's or resident's point of view. For example: Does this hospital provide the kind of care I would look for if I were sick? Is this a hospital where I would confidently bring my sick child? Does this nursing home provide the comfort I would wish for my parent? All comments received are brought to the attention of the administration.

Complaints take precedence over routine visits and are investigated as soon as possible. Members authorized to do so by resolution of the Committee, investigate each complaint thoroughly and make a full report. If regulations have been violated or if a complaint on another matter is justified, it is brought to the attention of the administration and the Board of the institution with recommendations for the correction of the problem. The Committee has found Boards and administration responsive to making corrections where necessary, but if the recommodations of the Committee are ignored or not put into effect within a reasonable period of time, the matter is referred to the Minister of Health.

People having concerns are encouraged to discuss them with the nursing supervisor, administrator, trustees or other officals of the facility, then if they are still not satisfied that the problem has been resolved, to write to the Committee.

All complaints are handled confidentially.

ACKNOWLEDGEMENTS

The Committee wishes to thank the Honourable Marvin Moore, former Minister of Hospitals and Medical Care for his support during his term of office.

During the year Mrs. Colleen wood resigned as vice-chairman and complaints co-ordinator. Her knowledge of the health facilities and her experience as complaints co-ordinator for the past fifteen years has been a valuable contribution.

INTRODUCTION

In executing the Committee's mandate in 1988, the members made routine, unannounced visits to health care facilities and senior citizens' lodges, reviewed and investigated complaints and made recommendations to the Minister of Hospitals and Medical Care (now Health), the Minister Responsible for Housing, and to local Boards.

1988 brought some changes to the health care system in Alberta. The Hon. Nancy Betkowski succeeded the Hon.. Marvin Moore as Minister of the Department of Health. A long Term Care Branch was established to replace the Nursing Home Team. The Patient Classification System is being developed. A task force to reduce the number of Long Term Care patients in active treatment hospitals was established with the Chairman of the Health Facilities Review Committee and another member participating.

The Committee wishes to acknowledge the hospitality offered to the members on their visits, and express appreciation for the time spent by administration and staff.

Also noteworthy is the work of volunteers in many facilities. The many services they provide are invaluable contributions to the health care system.

OBSERVATIONS AND RECOMMENDATIONS
ACTIVE TREATMENT HOSPITALS

1. There is an increasing demand for highly skilled personnel in critical care areas (ICU, CCU, Emergency and Neonatal). The need for education, recognition and incentive programs to attract nurses to these areas cannot be over emphasized.

2. Some patients have expressed a concern about the twelve hour shift schedule for nurses. This shift is attractive to staff because of the consecutive days off, but patients have commented that they "hate to bother the nurse - she seems so tired".

3. Some hospitals appear to be having difficulty attracting nurses to their facilities. The Commitee supports the concept of a nurse internship that provides rural as well as urban experience.

4. Most facilities offer in-service programs. However, the benefits of participation in training programs is not always seen as a high priority by either administration or staff, and staff often find it difficult to leave their work to attend training sessions. Funding should be set aside for training and for supplying the necessary relief staff.

5. Security is a major concern in most hospitals, particularly after hours. A formalized security plan should be developed and information shared between facilities.

6. The need for confidentiality cannot be over emphasized. The Committee has become aware of concerns relating to this, particularly in emergency rooms, where there is lack of privacy.

7. Many hospitals now have palliative care programs that include pastoral care, pain control and social support services. The need for these programs should be recognized.

8. Emergency Response Teams are seen as an effective way to prevent unnecessary admissions. A team, including a physician, a social worker and a home care nurse, based in the emergency department, would be able to effectively assess the need for admission, or alternatively plan and place appropriate personnel in the home. This type of program should be encouraged.

9. Of growing concern to hospital personnel is the fear of the spread of AIDS. Hospitals should be encouraged to provide ongoing information and education to staff.

10. Hospitals in general have a significant population of patients waiting for placement in Long term care facilities. Some have responded by providing programs such as Elder Day Care, where patients can be together for mental as well as social interaction and evaluation. The focus on rehabilitation and discharge planning is to be commended. Most facilities have some success stories that they can be proud of, however others have someone like Emma.

EMMA - A Profile

Emma is 86 years old and she sits in the hallway in a busy active treatment hospital. Doctors, nurses and others rush by - some barely glancing her way.

Emma is a patient waiting for placement in a long term care facility. The list is very long and there are several others ahead of her. She has been waiting for about fifteen months and there is a possibility she will never get there.

She used to be a busy wife and mother. Her husband is gone and her children live far away. She used to speak English, but now she only remembers her first language. Since she had a stroke, she cannot move very well on her own and she weeps frequently.

Some mornings are better than others. She doesn't like to be awakened too early . The regular staff respect this, but some mornings casual staff get her up early and try and hurry her along. This causes her to shout and attempt to hit out at the nurses.
Emma then sits in the hallway waiting.....

LONG TERM CARE

In 1982 the first report on long term care (the Hyde Report) was published. Since that time a number of positive changes have occurred.

The Nursing Home Act was changed in 1985 to include more hours of hands-on care (1.6 hours per patient per day), as well as provision for services of dietitians, physiotherapists, occupational and recreational therapists. Many facilities are not large enough or are too remote to attract the required personnel. Physiotherapists and occupational therapists are in great demand and not many choose to work in rural areas.

While the Nursing Home Act is in place for nursing homes, auxiliary hospitals still come under the Hospitals Act. Several months ago the Minister of Hospitals and Medical Care announced an interim measure to provide additional funding for nursing homes with over 20% of patients requiring auxiliary level care. Most facilities had 15% or less, and therefore did not meet the criteria.

Nursing staff, including Registered Nurses, Registered Nursing Assistants and Personal Care Aides express concern at the level of care they are expected to provide. Most say there is never enough time to provide extra services for the residents. As patient and family expectations grow nursing staff are feeling increasingly frustrated. A recommendation of the report of The Committee on Long Term Care for Senior Citizens is to combine nursing homes and auxiliary hospitals into long term care facilities. In the fall of 1988,assessments of patients were initiated under a team of consultants, as a method of implementing the proposed Patient Classification System.

There is now a Long Term Care Division under the Department of Health. The single point of entry, which has been a pilot project in Calgary and the Municipal District of Foothills seems to be well accepted and is now being implemented in several areas of the province. The purpose is to have one agency (i.e. Home Care) assess the client and recommend the most appropriate type of care. Although a lodge is not regarded as part of long term care, it is included in the single point of entry system.

More emphasis has been placed on Home Care, day hospitals and respite beds. Some facilities are able to provide respite beds for persons who need a bed for a week or weekend. An example is a disabled woman from a rural area who attends school in the city and needs some nursing care. She utilizes a bed in an extended care centre from Monday to Friday. The same bed would be utilized over the weekend by a person in the community whose spouse needs relief from providing care.

Day Hospitals or Day Programs provide support and therapy to those who might otherwise need to be hospitalized.

The Committee has observed residents in various age groups with chronic behaviour problems who appear to be inappropriately placed in long term care facilities. Residents with maladaptive behaviours must receive specialized care by trained staff. The Health Facilities Review Committee recommends that this serious concern receive immediate review.

A new combined Department of Health (Hospitals and Community Health), and the implementation of some of the recommendations contained in the report of The Committee on Long Term Care for Senior Citizens has positive implications for the future of long term care. With a number of support services in place and with continued emphasis on the health promotion and disease prevention, more seniors will be able to remain in their own homes.

SENIOR CITIZEN LODGES

In 1985 the Health Facilities Review Committee submitted a report on Senior Citizens' Lodges looking at utilization, type of resident, health care needs, etc. In the past three years the average age of a resident has increased with a greater number requiring assistance with medications and bathing.

Alberta's Co-ordinated Home Care Program is a service involved with most lodges across the Province, and provides information to managers regarding the residents' health care. Without this service a large number of residents would require nursing home accommodation.

In some urban areas except for some Home Care assistance with bathing, there are few services and activities available to residents. Several have expressed concern and disappointment at not being able to remain in a lodge because they need assistance with medications.

In many rural areas, lodges have activities co-ordinators. Residents appreciate having the social and mental stimulation of these programs, and generally have a greater sense of well being knowing these services are in place.

From observations and conversations with staff, the committee feels that courses on menu planning and meal preparation are extremely valuable, especially as some residents are on restricted diets, such as diabetic, low fat, saltfree or low calorie.

Many lodges have innovative approaches to menu planning, for example residents choose a "Dinner of the Month" and sometimes special festive menus are arranged.

Some time ago the Department of Health produced a booklet on menu planning for institutions. This publication is still available and would be of interest to people responsible for planning and preparing meals. The booklet also contains a useful list of publications on dietary subjects.

DID YOU KNOW?

The Alberta Association for Hospital Security was formed in 1982 by the Directors of Security Services of major hospitals in Edmonton, Calgary and Red Deer. The Association is recognized by the Alberta Hospital Association, and is a member of the American Association for Hospital Security and the International Association for Hospital Security. As such, the Association receives all pertinent information on what is happening in relation to hospital security throughout the world. Alberta is the only province in Canada to develop such an association.

AFTERCARE CARE SERVICES FOR THE CHRONIC MENTALLY ILL

The practice of treating mentally ill patients outside of large mental health institutions began in Canada in the mid 1950's, largely as a result of the discovery of psychotropic medications. There was also widespread conviction, shared by professionals and consumers alike, of the greater therapeutic potential of community settings compared to institutions which disrupt life style, foster stigma and encourage dependencies.

Between the years 1964 and 1979, there was a decrease of 75% in the hospitalization of patients. This phenomenon has resulted in larger numbers of patients receiving services in the community or healthcare agencies other than mental health hospitals. Many patients have, as a result, established a pattern of short repeated hospitalizations in mental health institutions. This raises the question of whether the patient's needs are being adequately addressed by the existing community services. At the same time, it may point to the need to strengthen the bridge between hospital and community care, and the need for adequate discharge planning and coordination. The situation has been exacerbated by society's interest in preserving and protecting the rights of the individual. As a result, there may be patients discharged into the community only to await the development of another crisis leading to their readmission.

In 1982, the chronic mentally ill population of Canada was estimated at 300,000. It is unlikely that a philosophy of care involving a return to the large scale institutionalization of mentally ill patients will be adopted in Canada. That being the case, appropriate community psychiatric services for the discharged patients must be implemented. These should involve a system that is assertive and has a rehabilitation philosophy by which patients with chronic disabilities are offered services for an extensive period of time. The objectives of the program should be to sustain the patient's tenure in the community and to enhance the patient's quality of life. This would involve providing community care and training with special emphasis on psychological rehabilitation. Optimistically, this support would encourage independence, reduce pathological dependence, maximize the patient's functioning level, control illness symptoms and enhance the patients overall quality of life.

Patients who are most in need are those who have been psychotic, who have been repeatedly hospitalized, who are poor, isolated, often unemployed, inadquately sheltered and unmotivated. They often do not actively seek treatment, having become disillusioned with psychiatric therapy. These are the patients who are the most burdened by terrifying symptoms, the most prone to dangerous crises, the most alienated from family and friends and the most alone and disadvantaged.

Aftercare of psychiatric patients is usually thought of as having five components:

HOUSING

Supervised living accommodation providing varying levels of supervision and independence is considered important for the chronically mentally ill. Alberta Mental Health Services have developed a method of categorizing residential accommodation into standardized levels of care and supervision, which can be applied when making a choice for housing for a particular patient..

VOCATIONAL REHABILITATION

Rehabilitation services appropriate for ex-patients are provided by voluntary organizations as well as government agencies. The special needs of ex-psychiatric patients have to be recognized, and services and programs specific to their needs developed. Lines of communication have to be strengthened between the medical psychiatric professionals and the vocational rehabilitation field. Life skills programs are important in meeting the needs of recently discharged patients and others with various types of coping difficulties and social inadequacies.

SOCIAL RECREATION

Among recognized components of psychiatric aftercare, programs geared towards providing social/recreational opportunities are perhaps the most undervalued. A major feature of many mental disorders is difficulty in forming, maintaining and enhancing individual relationships and social networks. Many chronically ill mental patients who live in the community are leading lonely, isolated and meaningless lives. Many lack social skills; others have cognitive deficiencies or have recurrent symptoms which have long alienated them from their social networks. Some have found comfort in the social structure and programs of large institutions, which accept them readily without any effort on their part. There has to be an alternative to this dependency by meeting their needs through special programs. Community based special programs should be designed and operated with the assistance of those specially trained in psychiatric rehabilitation.

MEDICAL/THERAPEUTIC PROGRAMS

Most patients discharged from hospital programs are referred either to family physicians or to psychiatrists. In addition , many are referred, or refer themselves, to non-medical private practitioners, Alberta Mental Health Family Service agencies, family therapy programs, life skill groups and others. For a patient to benefit fully in this area, the referring, assessing and treating of the patient has to be fully integrated. In addition, there has to be complete cooperation between the various programs and agencies with respect to obtaining important information on the condition, needs and progress of the patient.

FOLLOW - UP

This function is best carried out in community-based clinics, although some hospitals do have follow-up programs. There could be two potential difficulties with a hospital-based program. Firstly, hospitals have a traditional built in rhythm of acute, short-term care which can lead to the neglect of the program. Secondly, in successful programs, patients keep coming back, which may lead to too much dependence on their part. Experience has led more and more people to favour community-based follow-up programs. The chief advantage of a hospital based program is that it can enhance continuity of care and accessibility to care, particularly when crises occur. In case of a hospital based program it is recommended that there be a strong community focus and utilization of community resources.

Among the various follow-up programs, the "case manager" model is increasingly favoured. It involves a staff mix of highly trained mental health professionals and para-professionals, who are provided with special training in rehabilitation and liaison consultation. Their functions include case identification, assessment, rehabilitation programing, follow-up, community service liaison, and coordination, advocacy and evaluation. Staff involved with programs of this type are generally referred to as "case manager". The objectives of the program are improved instrumental functioning, reduced social isolation and appropriate utilization of aftercare resources.

A successful aftercare service has the following characteristics:

(a) It includes the five essential components described above.

(b) There is proper balance between medical/therapeutic services and the other elements.

(c) Emphasis is on the learning of new behaviours and skills rather than the treatment of illness.

(d) As chronic patients move back and forth through a range of services, aftercare is flexible, individual and accessible and incorporates a long-term case management approach. There is close communication among those agencies and individuals who may, at times, be simultaneously involved with the patient.

(e) There is active outreach or assertive follow-up.

(f) Aftercare is community-based in order to keep the locus of care away from institutions.

Aftercare services for the chronic mentally ill is an integral part of the treatment and care continum. This is accomplished within the framework of a system which is philosophically unified at all levels, and has the staffing capability to deliver a complete range of services appropriate to the special needs of the mentally ill. If the policy of not retaining patients in mental health institutions is to remain the basic philosophy in caring for the mentally ill, no inpatient beds for the mentally ill can be considered without equal attention to the concomitant aftercare services.

APPENDIX I

MEETINGS WERE HELD WITH THE FOLLOWING:

Mrs. Dianne Mirosh, M.L.A.
Chairman, Committee on Long Term Care for Senior Citizens

Senior Citizens Homes Association
Mrs. M. Balsillie, President
Mrs. Lois Porter, Board Chairman, Greater Edmonton Foundation
Mr. Ray Clark, Board Chairman, Greater Calgary Foundation
Mr. David Foley, Executive Director, Greater Edmonton Foundation
Mr. Dale Aasen, Executive Director, Greater Calgary Foundation

Long Term Care Committee, Alberta Hospitals Association

Long Term Care In-Service Resource Centres
Mrs. Joyce M. Church, Manager, Calgary
Mrs. Laveena Gittens, Manager, Edmonton

Department of Health
Mr. Rhéal LeBlanc, Deputy Minister
Mr. M.H. Lamb, Director, Institutional Operations Branch

Alberta Hospitals Association
Mr. Ed Crowther, Board Chairman
Mr. D. Macgregor, President

Christian Labour Association of Canada
Mr. Co J. Vanderlaan, Alberta Director
Mr. John P. Kolk, Chairman of the Taskforce on Nursing Homes

APPENDIX II

CONVENTIONS ATTENDED

Alberta Hospitals Association

Senior Citizens' Homes Association

SEMINARS, CONFERENCES, and WORKSHOPS

People and Progress Conference,Hospital District 24
Conference on Aids, Misericordia Hospital, Dept. of Psychiatry
Rural Hospitals Conference, Alberta Hospitals Association
Patient Classification, Department of Health
Single Point of Entry System, Department of Health

APPENDIX III

Of the following facilities, 83 acute care hospitals, 21 auxilliary hospitals, 44 nursing homes, 84 senior citizens lodges and 2 mental health hospitals were visited in 1988

HOSPITALS

ATHABASCA, Athabasca Municipal
BANFF, Mineral Springs
BARRHEAD, Barrhead General
BASHAW, Bashaw General
BASSANO, Bassano General
BEAVERLODGE, Beaverlodge Municipal
BENTLEY, Bentley General
BLACK DIAMOND, Oilfields General
BLAIRMORE, Crowsnest Pass General
BONNYVILLE, Health Centre
BOW ISLAND, Bow Island Health Care Centre
BOYLE, Boyle General
BRETON, Breton General
BROOKS, Brooks Health Centre
CALGARY, Alberta Children's Provincial General
CALGARY, Calgary General
CALGARY, Colonel Belcher
CALGARY, Foothills Provincial General
CALGARY, Holy Cross
CALGARY, Peter Lougheed Hospital
CALGARY, Rockyview General
CALGARY, Salvation Army Grace
CALGARY, Tom Baker Cancer Centre
CAMROSE, St. Mary's
CANMORE, Canmore Municipal
CARDSTON, Cardston Municipal
CASTOR, Our Lady of the Rosary
CEREAL, Cereal Municipal
CLARESHOLM, Claresholm General
COALDALE, Coaldale Community
COLD LAKE, Cold Lake Regional
CONSORT, Consort Municipal
CORONATION, Coronation Municipal
DAYSLAND, Daysland General
DESMARIAS, St. Martin's Health Centre
DEVON, Devon General
DIDSBURY, Mountain View Health Care Centre
DRAYTON VALLEY, Health Care Complex
DRUMHELLER, Drumheller Regional Health Complex
ECKVILLE, Eckville Municipal
EDMONTON, Alberta Hospital
EDMONTON, Charles Camsell
EDMONTON, Edmonton General
EDMONTON, Glenrose Provincial General
EDMONTON, Grey Nuns Hospital
EDMONTON, Misericordia
EDMONTON, Royal Alexandra
EDMONTON, Walter C. MacKenzie
EDMONTON, W.W. Cross Cancer Institute
EDSON, St. John's Health Care Complex
ELKPOINT, Elk Point Municipal
ELNORA, Elnora General
EMPRESS, Empress Municipal
FAIRVIEW, Fairview General
FORT MACLEOD, Health Care Centre
FORT MCMURRAY, Fort McMurray Regional
FORT SASKATCHEWAN, Fort Saskatchewan General
FORT VERMILION, St. Theresa General
FOX CREEK, Fox Creek
GALAHAD, Galahad General
GLENDON, Glendon Municipal
GRAND CACHE, Grande Cache General
GRAND PRAIRIE, Queen Elizabeth II
GRIMSHAW, Grimshaw / Berwyn & District
HANNA, Hanna General
HARDISTY, Hardisty General
HIGH LEVEL, High Level Community Health Centre
HIGH PRAIRIE, High Prairie Regional Health Complex
HIGH RIVER, High River General
HINTON, Hinton General
HYTHE, Hythe Municipal
INNISFAIL, Innisfail Health Care Centre
ISLAY, Islay Municipal
JASPER, Selon General
KILLAM, Killam General
LAC LA BICHE, William Cadzow General Hospital
LACOMBE, Lacombe General
LAMONT, Archer Memorial
LEDUC, Leduc General
LETHBRIDGE, Lehtbridge Regional
LETHBRIDGE, St. Michael's General
MAGRATH, Magrath Municipal

MANNING, Manning Municipal
MANVILLE, Manville Municipal
MAYERTHORPE, Mayorthorpe General
MCLENNAN, Sacred Heart
MEDICINE HAT, Medicine Hat and District (General Centre)
MILK RIVER, Border Counties General
MUNDARE, Mary Immaculate General
MYRNAM, Myrnam Municipal
OLDS, Olds Municipal
OYEN, Big Country General
PEACE R!VER, Peace River Municipal
PICTURE BUTTE, Picture Butte Municipal
PINCHER CREEK, Pincher Creek Health Care Centre
PONOKA, Alberta Hospital
PONOKA, Ponoka General
PROVOST, Provost Municipal (Health Care Centre)
RAYMOND, Raymond Municipal
RED DEER, Red Deer Regional
REDWATER, Thorhild County General
RIMBEY, Rimbey General
ROCKY MOUNTAIN HOUSE, Rocky Mountain House General
SLAVE LAKE, Slave Lake General
SMOKY LAKE, George McDougall Memorial
SPIRIT RIVER, Central Peace General
STETTLER, Stettler General
STONY PLAIN, Stony Plain Municipal
STRATHMORE, Valley General Hospital
ST. ALBERT, Sturgeon General
ST. PAUL, St. Therese General
SUNDRE, Sundre General
SWAN HILLS, General
TABER, Taber Health Care Complex
THREE HILLS, Three Hills Health Care Complex
TOFIELD, Tofield Health Centre
TROCHU, St. Mary's Health Care Centre
TWO HILLS, Two Hills Health Care Centre
VALLEYVIEW, Valleyview Health Centre
VEGREVILLE, St. Joseph's General
VERMILION, Vermilion Health Care Complex
VIKING, Viking General
VILNA, our Lady's General
VULCAN, Vulcan General
WAINWRIGTH, Wainwright & Dist. Health Care Complex
WESTLOCK, Immaculata General
WETASKIWIN, Wetaskiwin General
WHITECOURT, Whitecourt General
WILLINGDON, Mary Immaculate General

AUXILIARY HOSPITALS

ATHABASCA, Athabasca
BARRHEAD, Dr. W.R. Keir Care Centre
BLACK DIAMOND, Oilfields Aux.
BOW ISLAND, Bow Island
BROOKS, Brooks
CALGARY, Bethany
CALGARY, Colonel Belcher
CALGARY, Crossbow
CALGARY, Dr. Vernon Fanning Extended Care
CALGARY, Foothills
CALGARY, Glenmore Park
CALGARY, Sarcee
CAMROSE, Bethany
CANMORE, Auxiliary
CARMANGAY, Little Bow Municipal
CARDSTON, Cardston
CLARESHOLM, Willow Creek - Claresholm
COLD LAKE, Regional
CORONATION, Paintearth
DISBURY, Mountain View Health Care Centre
DRAYTON VALLEY
DRUMHELLER, Regional Health Complex
EDMONTON, Allen Gray
EDMONTON, Dickinsfield Extended Care Centre
EDMONTON, Good Samaritan
EDMONTON, Grandview
EDMONTON, Lynnwood
EDMONTON, Mewburn Veterans Centre
EDMONTON, Millwoods Shepherd's Care Centre
EDMONTON, Norwood
EDMONTON, St. Joseph's
EDMONTON, St. Michael's
EDMONTON, University of Alberta.
(Aberhart Pavilion)
EDMONTON, Youville Geriatric Services
GRAND PRAIRIE, Queen Elizabeth II
HIGH RIVER, High River
INNISFAIL, Innisfail Health Care Centre (Aux.)
ISLAY, Islay
KILLAM, Flagstaff
LAC LA BICHE, Lac La Biche (William Cadzow)
LACOMBE, Lacombe
LAMONT, Archer Memorial
LAMONT, Lamont
LETHBRIDGE, Lehtbridge Regional
(Rehab. Centre)
LLYODMINISTER, Lloydminster Auxiliary
MANNVILLE, Municipal
MEDICINE HAT, Medicine Hat & District
(Dr. McCharles)
MUNDARE, Mundare
OLDS, Auxiliary
OYEN, Big Country
PEACE RIVER, Peace River / Fairview
PINCHER CREEK, Pincher Creek
RADWAY, Radway Health Care Centre
RED DEER, Dr. Richard Parsons
RIMBEY, Rimbey
ROCKY MOUNTIAN HOUSE, Rocky Mountain
House
SMOKY LAKE
STETTLER, Dr. A.E. Kennedy
TABER
THREE HILLS
TOFIELD, Municipal
TROCHU, St. Mary's
TWO HILLS, Health Care Complex
VEGREVILLE, (Minburn - Eagle)
VERMILLION, Health Care Complex
WAINWRIGHT, Wainwright & Distrcit
Health Centre
WESTLOCK, Thorhild - Westlock
WETASKIWIN, Wetaskiwin
WHITELAW, Hotel Dieu de St. Joseph

NURSING HOMES

AIRDRIE, Bethany Care Centre
ATHABASCA, Extendicare
BARRHEAD, Barrhead
BLAIRMORE, Crowsnest Pass
BONNYVILLE, Extendicare
BROOKS, Newell Health Centre
CALGARY, Bethany Care Centre
CALGARY, Beverly
CALGARY, Bow-Crest
CALGARY, Bow View
CALGARY, Brentwood
CALGARY, Cedars Villa
CALGARY, Central Park Lodge
CALGARY, Chinook
CALGARY, Extendicare
CALGARY, Forest Grove Care Centre
CALGARY, George Boyack
CALGARY, Glamorgan
CALGARY, Mayfair
CALGARY, Sarcee
CALGARY, Scottish
CALGARY, Southwood
CAMROSE, Bethany
CARDSTON, Grandview
COCHRANE, Bethany Care Centre
CORONATION, Coronation-Paintearth
DIDSBURY, Mountain View Health Care Centre
DRAYTON VALLEY
DRUMHELLER, Regional Health Complex
EDMONTON, Central Park Lodge
EDMONTON, Dickinsfield Extended Care Centre
EDMONTON, Norwood
EDMONTON, Extendicare North
EDMONTON, Extendicare Southgate
EDMONTON, Good Samaritan Mount Pleasant
EDMONTON, Good Samaritan Southgate
EDMONTON. Hardisty
EDMONTON, Jasper Place Central Park Lodge
EDMONTON, Jubilee Lodge
EDMONTON, Millwoods Shepherds Care Centre
EDMONTON, Roger Parker Pavilion
EDMONTON, St. Michael's
EDMONTON, Venta
EDSON, Edson
FAIRVIEW, Fairview
FORT MACLEOD, Extendicare
FORT SASKATCHEWAN, Rivercrest Lodge
GRAND PRAIRIE, Central Park Lodge
GRANDE PRAIRIE, Queen Elizabeth II
HANNA, Palliser
HIGH PRAIRIE, J.B. Wood
HIGH RIVER, High River
HYTHE, Hythe
LACOMBE, Lacombe
LAMONT, Lamont
LEDUC, Extendicare
LEDUC, Salem Manor
LETHBRIDGE, Edith Cavell
LETHBRIDGE, Extendicare
LETHBRIDGE, Southland
LINDEN, Linden
LLOYDMINISTER, Dr. Cooke
MAYERTHORPE, Extendicare
MCLENNAN, Our Lady of the Lake
MEDICINE HAT, Central Park Lodge
MEDICINE HAT, Sunnyside
MIDNAPORE, Father Lacombe
OLDS, Olds Nursing Home
PEACE RIVER, Sutherland
PONOKA, Northcott Lodge
PROVOST, Provost Municipal Health Care Centre
RED DEER, Red Deer
RED DEER, Valley Park Manor
RED DEER, West Park
ST. ALBERT, Youville
ST. PAUL, Extendicare
SHERWOOD PARK, Sherwood Park
SMOKY LAKE, Smoky Lake
STETTLER, Steller
STONY PLAIN, Good Samaritan
STRATHMORE, Nursing Home
TABER, Nursing Home
TOFIELD, Health Centre
TROCHU, St. Mary's
TWO HILLS, Health Care Centre
VEGREVILLE, Vegreville
VERMILLION, Alice Keith Centre
VIKING, Extendicare
VULCAN, Extendicare
WESTLOCK, Westlock
WETASKIWIN, Wetaskiwin

SENIOR CITIZENS' LODGES

ANDREW - Andrew Senior Citizens' Lodge
ATHABASCA - Pleasant Valley Lodge
BARRHEAD - Hillcrest Senior Citizens' Lodge
BASHAW - Bashaw Valley Lodge
BASSANO - Playfair Lodge
BERWYN - Autumn Lodge
BLACK DIAMOND - High Country Lodge
BLAIRMORE - York Creek Lodge
BONNYVILLE - Bonny Lodge
BOW ISLAND - Pleasant View Lodge
BOYLE - Wild Rose Villa
BROOKS - Newbrook Lodge
CALGARY - Beaver Dam Lodge #1200
CALGARY - Bow Valley Lodge #100
CALGARY - Bow Valley Lodge #200
CALGARY - Bow Valley Lodge #300
CALGARY - Bow Valley Lodge #1100
CALGARY - Confederation Park #1000
CALGARY - Elbow Valley Lodge #700
CALGARY - Elbow Valley Lodge #800
CALGARY - Jacques Lodge #400
CALGARY - Jacques Lodge #500
CALGARY - Jacques Lodge #600
CALGARY - James Shouldice Lodge #1300
CALGARY - Rundle Lodge #900
CALGARY - Valleyview Lodge #1400
CAMROSE - Stony Creek Lodge
CANMORE - Bow River Lodge
CARDSTON - Chinook Lodge
CASTOR - Paintearth Lodge
CLARESHOLM - Porcupine Hills Lodge
COALDALE - Sunny South Lodge
COCHRANE - Big Hill Lodge
COLD LAKE - Cold Lake Senior Citizens' Lodge
CONSORT - Consort Senior Citizens' Lodge
CROSSFIELD - Rocky View Lodge
DRAYTON VALLEY - Shangri - La Lodge
DRUMHELLER - Sunshine Lodge
ECKVILLE - Eckville Manor House
EDMONTON - Belvedere Lodge
EDMONTON - Bethany Lodge
EDMONTON - Beverly Lodge
EDMONTON - Elmwood Lodge
EDMONTON - Kiwanis Place Lodge
EDMONTON - McCauley Lodge
EDMONTON - McQueen Lodge
EDMONTON - Meadowlark Lodge
EDMONTON - Northway Lodge
EDMONTON - Ottewell Lodge
EDMONTON - Pleasantview Place Lodge
EDMONTON - Queen Alexandra Lodge
EDMONTON - Rosslyn Lodge
EDMONTON - Virginia Park Lodge
EDSON - Parkland Senior Citizens' Lodge
ELK POINT - Heritage Lodge
EVANSBURG - Sunshine Lodge
FALHER - Villa Beausejour
FORESTBURG - Big Knife Comple Lodge
FORT CHIPEWYAN - Ayabashaw House
FORT MACLEOD - Pioneer Lodge
FORT SASKATCHEWAN - Dr. Turner Lodge
GIBBONS - Spruce View Manor
GRANDE PRAIRIE - Heritage Lodge
GRANDE PRAIRIE - Pioneer Lodge
GRANDE PRAIRIE - Wild Rose Manor
HANNA - Hanna Lodge
HIGH PRAIRIE - Pleasant View Lodge
HIGH RIVER - Medicine Tree Lodge
HINES CREEK - Homesteader Lodge
HOLDEN - Holden Lodge
HYTHE - Hythe Pioneer Home
INNISFAIL - Autumn Glen Lodge
LAC LA BICHE - Lacalta Lodge
LACOMBE - Lacombe Lodge
LAMONT - Beaverhill Pioneer Lodge
LEDUC - Planeview Lodge
LEGAL - Chateau Sturgeon Lodge
LETHBRIDGE - Alberta Rose Lodge
LETHBRIDGE - Blue Sky Lodge
LETHBRIDGE - Golden Acres Lodge
LETHBRIDGE - Green Acres Lodge
LETHBRIDGE - Heritage Lodge
LLOYDMINSTER - Pioneer Lodge
MAGRATH - Diamond Willow Terrace Lodge
MANNING - Del - Air Lodge
MAYERTHORPE - Pleasant View Lodge
MEDICINE HAT - Cypress View Lodge
MEDICINE HAT - Teeoda Lodge
MEDICINE HAT - Wild Rose Senior Citizens' Lodge
MILK RIVER - Prairie Rose Lodge
MORINVILLE - Heritage Place Lodge
MUNDARE - Father Filas Senior Citizens' Lodge
MYRNAM - Eagle View Lodge
NANTON - Silver Willow Lodge
OLDS - Mountainview Lodge
OYEN - Prairie Home Lodge
PEACE RIVER - Heritage Tower
PICTURE BUTTE - Piyami Lodge

PEACE RIVER - Heritage Tower
PICTURE BUTTE - Piyami Lodge
PINCHER CREEK - Crest View Lodge
PONOKA - Golden Leisure Lodge
PROVOST - Hillcrest Lodge
RAYMOND - Ridgeview Lodge
RED DEER - Pines Lodge
RED DEER - Piper Creek Lodge
REDWATER - Redwater Diamond Spring Lodge
RIMBEY - Parkland Manor
ROCKY MOUNTAIN HOUSE - Westview Lodge
SEDGEWICK - Flagstaff Lodge
SHERWOOD PARK - Sherwood Park Lodge
SMOKY LANE - Bar - V - Nook Manor
SPIRIT RIVER - Pleasant View Lodge
ST. ALBERT - Chateau Mission Court
ST. PAUL - Sunnyside Manor
STETTLER - Heart Haven Home
SUNDRE - Foothills Retreat Lodge
STONY PLAIN - Meridian Lodge
STRATHMORE - Wheatland Lodge
SYLVAN LAKE - Sylvan Lake Lodge
TABER - Clearview Lodge
THORHILD - Thorhild Lodge
THREE HILLS - Golden Hills Lodge
TOFIELD - Tofield Lodge
TWO HILLS - Hillside Senior Citizens' Lodge
VALLEYVIEW - Red Williow Lodge
VEGREVILLE - The Homestead
VERMILLION - Vermillion Valley
VIKING - Vialta Lodge
VILNA - Vilna Lodge
VULCAN - Peter Dawson Lodge
WAINWRIGHT - Battle River Lodge
WARBURG - Clover Leaf Manor
WESTLOCK - Pembina Lodge
WESTLOCK - Smithfield Lodge
WETASKIWIN - Peace Hills Lodge
WILLINGDON - Eagle Hill Manor
WINFIELD - West Pine Lodge

APPENDIX IV

GOVERNMENT OF THE PROVINCE OF ALBERTA

HEALTH FACILITIES REVIEW COMMITTEE ACT

Revised Statutes of Alberta 1980, Chapter H-4
as amended to January 9, 1984

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HEALTH FACILITIES REVIEW COMMITTEE ACT

CHAPTER H-4

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HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "Committee" means the Alberta Health Facilities Review Committee and includes a sub-committee established under section 3;

(b) "hospital" means

(i) an approved hospital under Hospitals Act,

(ii) any other hospital, institution or other facility for the treatment and care of persons that is owned and operated by the Government of Alberta, except those operated under the administration of the Minister of Social /Services and Community Health or those that receive their current operating funds or part of them from a supply vote that is under the administration of a member of the Executive Council other than the Minister of Hospitals and Medical Care,

(ii.1) a mental health hospital under the Mental Health Act,

(iii) a contract nursing home as defined in the Nursing Homes Act, or

(iv) a home or unit operated under the Senior Citizens Housing Act;

(c) "Minister" means the Minister of Hospitals and Medical Care;

(d) "patient", with reference to a home or unit operated under the Senior Citizens Housing Act, means a person who resides in that home or unit.

RSA 1980 cH-4 s1; 1981 c72 s10

Committee established

2(1) There is hereby established a committee called the "Alberta Health Facilities Review Committee" consisting of not more than 12 members appointed by the Minister.

(2) The members of the Committee may include members of the Legislative Assembly who are not members of the Executive Council.

(3) An order appointing a member of the Committee may provide for his term of office but in the absence of such a provision, the term of office of a member is one year from the effective date of his appointment and thereafter until his successor is appointed.

(4) The Minister shall designate one of the members of the Committee as chairman and another as a vice-chairman and, unless the order otherwise provides, the term of office of a chairman and, unless the order otherwise provides, the term of office of a chairman or vice-chairman so designated is one year from the effective date of the designation and until their respective successors are thereafter designated.

(5) The vice-chairman is the acting chairman of the Committee in the event of the absence or inability to act of the chairman or a vacancy in the office of chairman.

RSA 1980 cH-4; s2 1983 c81 s4

Sub-committees

3(1) The Committee may

(a) establish one or more sub-committees to perform those duties and functions and exercise those powers of the Committee prescribed by the Committee, and

(b) appoint as members of a sub-committee not less than 3 members of the Committee.

(2) When a sub-committee is established, the Committee shall designate a member of a sub-committee to preside over the sub-committee.

(3) A member of the Committee may be appointed to more than one sub-committee.

(4) A majority of the members appointed to a sub-committee constitute a quorum of the sub-committee.

(5) A decision or other action made or taken by a sub-committee at which its quorum is present is the decision or action of the Committee and binds all members of the Committee.

(6) Two or more sub-committee may act simultaneously.

(7) If a sub-committee is performing a duty or function or exercising its powers and one or more

members of the sub-committee are absent during a portion of the time that the sub-committee is performing a duty or function or exercising a power, the remaining members of the sub-committee that are present may, if they constitute a quorum of the sub-committe, perform the duty or function and exercise the power of the sub-committee.

(8) Notwithstanding that a sub-committee is established under this section, the Committee may also perform any duty or function or exercise any power that it prescribed the sub-committee to perform or exercise.

RSA 1980 cH-4 s3

Remuneration and expenses

4 The Minister

(a) may prescribe the rates of remuneration payable to members of the Committee other than those who are employees of the Government or members or employees of an agency of the Government, and

(b) may authorize the payment of travelling and living expenses for members of the Committee while outside their normal place of residence in the course of performing their duties.

RSA 1980 cH-4 s4; 1983 c81 s4

Staff

5(1) The Minister may appoint an employee of the Government under his administration as the Executive Director of the Committee who shall under the direction of the chairman of the Committee assist the Committee in carrying out its duties and functions and exercising its powers.

(2) The Minister shall provide to the Committee the services of employees of the Government under his administration and supplies for the purpose of carrying out secretarial, clerical and related work that the Committee may reasonably require to enable it to carry out its duties and functions and exercise its powers.

RSA 1980 cH-4 s5

Meetings

6 The Committee may, with the approval of the Minister, make rules governing the calling of its meetings , the quorum required at its meetings, the procedure at its meetings, and any other matter relating to the conduct of its business and affairs.

RSA 1980 cH-4 s6; 1983 c81 s4

Visiting hospital

7(1) The Committee shall from time to time visit all hospitals for the purpose of reviewing and inspecting them and the manner in which they are operated.

(2) The Minister may from time to time request the Committee to conduct a visit to a hospital for the purposes of reporting to the Minister on any matter that the Minister specifies in his request.

RSA 1980 cH-4 s7

Investigation of hospital

8 If a complaint is made to the Committee by or on behalf of a patient in a hospital, the Committee shall investigate the care and treatment and the standards of accommodation received by that patient or any other patient in the hospital.

RSA 1980 cH-4 s8

Entry of hospital

9 For the purpose of carrying out a visit or an investigation under this Act the Committee may enter a hospital at any reasonable hour.

Inspection of hospital records

10 (1) The Committee, with respect to a visit or an investigation under this Act, is entitled to access to the records of the hospital for the purpose of inspecting them, making copies of them or taking extracts from them.

(2) Subsection (1) does not apply to

(a) the financial records of the hospital that relate to the operation of the hospital, or

(b) the medical and clinical records of a patient unless the patient or his guardian gives his consent to those records being inspected.

RSA 1980 cH-4 s10

Exemption

11 Nothing in this Act shall be construed as empowering the Committee or other person acting under this Act to inquire into the financial affairs of the hospital that relate to the operation of the hospital.

RSA 1980 cH-4 s11

Persons acting on behalf of of Committee

12(1) The Committee may authorize

(a) a member of the Committee to carry out a visit or investigation on behalf of theCommittee or

(b) subject to the approval of the Minister, an employee of the Government under the Minister's administration to carry out a specific inquiry on behalf of the Committee in respect of a visit or investigation.

(2) When a member of the Committee or other person has carried out a visit, investigation or specific inquiry on behalf of the Committee, that member or person shall report his findings to the Committee.

RSA 1980 cH-4 s12

Complaint officer

13(1) The Committee may designate

(a) a member of the Committee, or

(b) with the approval of the Minister, an employee of the Government who is under the administration of the Minister.

as a complaint officer.

(2) The complaint officer shall on behalf of the Committee

(a) make preliminary inquiries, or

(b) if directed to do so by the chairman of the Commitee, make investigations into complaints received under section 8 and report the results of the inquiry or investigation to the Committee.

(3) Members of the Committee at the request of the chairman of the Committee may assist the complaint officer in the carrying out of his duties.

RSA 1980 cH-4 s13

Powers of Committee members

14 A member of the Committee or an employee of the Government carrying out a visit, investigation or other matter on behalf of the Committee has the same powers that the Committee would have if it were carrying out the visit, investigation or other matter.

RSA 1980 cH-4 s14

Court order

15(1) If the Committee, a member of the Committee or an employee of the Government acting on behalf of the Committee is refused entry to a hospital for the purposes of conducting a visit or an investigation, the chairman of the Committee or a person designated by him may apply to the Court of Queen's Bench by originating notice for an order permitting the Committee, member or employee to

(a) enter the hospital at any reasonable hour and conduct the visit or investigation, and

(b) require the production of any records of the hospital, other than those referred to in section 10(2).

(2) An application under subsection (1) may be made ex parte, if the Court considers it proper to do so in the circumstances..

RSA 1980 cH-4 s15

Annual Report

16 (1) As soon as possible after the end of each year, the Committee shall prepare and submit to the Minister a report summarizing its activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then in session, and if not, within 15 days after the commencement of the next ensuing session.

RSA 1980 cH-4 s16

Act binds Crown

17 This Act binds the Crown.

RSA 1980 cH-4 s17